2014 Coordinated Care Model Alignment Workgroup
January 25, 2016
3:00 p.m. – 4:30 p.m.

Lincoln Building (Mary conference room – Suite 850)
421 SW Oak Street
Portland, OR 97204

Public listen-only conference line: 888-363-4734; Participant code: 1050791

#	Time	Item	Lead
1	3:00	Spreading the Coordinated Care Model in the commercial market	Jennifer Heilbronner, Metropolitan Group
2	3:25	Finalize model contract, review fact sheets, and next steps	Beth Waldman, Bailit Health Purchasing Veronica Guerra, OHA
3	3:45	Return on Investment brainstorm	Beth Waldman and Veronica Guerra
4	4:20	Public Comment	
5	4:30	Adjourn Meeting	

Upcoming meetings:

- March 17, 2016 2:00-4:00pm
- June 16, 2016 2:00-4:00pm

Draft Model Contract

Introduction to Model Contract:

The purpose of this Model Contract is to assist self-funded employers to implement aspects of the Coordinated Care Model (CCM)[1] through an agreement with a Third Party Administrator (TPA). Many of the terms of this Model Contract could also be used by fully-insured employers in agreements with health insurers. In addition, the Model Contract can be used by employers regardless of whether all of their employees are located in Oregon.[2] The concepts of the CCM are not unique to Oregon and are being implemented nationally by employers.

Key elements of the CCM include:

- Best practices to manage and coordinate care
- Sharing responsibility and engaging members in better health
- Measuring provider performance
- Paying for outcomes and health
- Providing information to Participants about price and quality
- Financially sustainable rate of health care cost growth (per member)

The Model Contract, which goes beyond a Scope of Work, includes the following key elements of a Contract based on CCM principles.

- Contract Purpose: This section lays out the purpose of the Contract and the goals that the employer is trying to accomplish through the Contract.
- Comprehensive Services: This section details the services that the employer will provide as covered services under the Contract. This language provides optional language for employers to consider regarding member selection of a primary care physician, different benefit design incentives, and potential cost-sharing structures.
- Network Management: This section includes requirements for the TPA to provide an adequate network to serve the employer's covered population and also details requirements related to managing the provider network.

[1] For more information on the CCM, please see http://www.oregon.gov/DAS/PEBB/2015Benefits/Coordinated%20Care%20Model.pdf [

[2] One exception may be the specific quality measurement language, which may need to be modified to incorporate measurement alignment across states and not just in Oregon.

- Evidence-Based Care: This section is focused on requirements to provide evidence-based care, and the monitoring of adherence to those requirements.
- Quality: This section provides the quality requirements for the TPA, including implementation of a Quality Improvement Plan and use of standardized quality measures to assess plan and provider performance.
- Payment Strategies: This section provides options that employers may require for value-based payment strategies, including population-based payments, pay-for-performance, episode-based payments, strategies designed to reduce waste, and strategies designed to support primary care.
- Information Technology: This section focuses on the IT requirements for the TPA as well as for network providers, including use of electronic health records, information sharing and analysis.
- Transparency: This section provides employer requirement options regarding disclosure of provider performance and price to facilitate Participant comparisons.
- Contractor Performance: This section describes how the employer will monitor the TPA's performance, and apply financial consequences to performance through performance guarantees and financial incentives and disincentives.

There are a number of other requirements that should be included in a TPA Contract, but are not addressed here because they concern standard administrative services and are not specific to the CCM, For example, TPA contracts should address customer services, development of a provider directory, claims payment and other IT infrastructure, provision of encounter data, and confidentiality requirements. Employers should work with their TPA to ensure that the Model Contract is supplemented with additional information about these services that would be required in a Contract. In addition, the Employer's agreement with the TPA will include a separate document that provides a detailed description of Covered Services and cost-sharing parameters.

Where the Model Contract includes explanatory language for the purchaser that would not be part of an agreement with a TPA, it is marked with brackets and in italics. Recognizing that purchasers will be in different places and comfort levels with some aspects of the Coordinated Care Model, there are a number of elements marked "Alternative" or "Optional", throughout the Contract. Alternative language can be substituted for the model language directly above it in order to make a stronger requirement. Likewise, Optional elements are those that can be added in addition to the model language to make a stronger requirement. Both alternative and optional elements are also identified by use of italics.

Definitions

Behavioral Health means services related to either mental health and/or addiction services.

Care Management means services for Members with one or more chronic medical conditions (including but not limited to diabetes, chronic obstructive pulmonary disease, congestive heart failure and hypertension) and are at high risk of future inpatient and Emergency Department (ED) use. Such services include coordination of care, patient engagement and addressing social determinants of health, all with the goal of improving the Member's health status and averting the need for avoidable future inpatient and ED utilization.

Case Management means a program that supports Members with complex acute health care needs who require a case management process that fully integrates medical, behavioral, acute care, medication management and patient education into a seamless experience, ensuring Members receive the right care at the right time, are engaged, understand the care plan and receive ongoing support from their care team in order to prevent avoidable future inpatient and ED utilization.

Clinical Protocols means standardized tools designed for a particular medical condition or procedure that provides clear care guidelines based on scientific evidence and organizational consensus regarding the best way to manage the condition or procedure.

Concurrent Review means the review of a service, typically in a facility setting, while a Participant is in that setting to confirm that the service is medically necessary and reimbursable under the Plan.

Coordinated Care Model (CCM) means a model of care delivery through which purchasers, health plans and providers work collaboratively to get better value and higher quality of care at an affordable price. The key elements of the CCM include best practices to manage and coordinate care, shared responsibility for health, transparency in price and quality, measuring performance, paying for outcomes and health and a sustainable rate of growth.

Electronic Health Record is a digitalized health record for an individual that may be shared among health care providers.

Employer means a sponsor of a group health plan with specified benefit coverage through the TPA.

Episode-based Payment means payment for a group of related services that are bundled together to treat a specific intervention. An example of an Episode-based Payments is one payment for a set of maternity care services (pre-natal, delivery and six weeks post-natal).

Evidence-Based Care means the conscientious, explicit and judicious use of current best evidence in making decisions about the care of patients, including finding, assessing and

implementing methods of diagnosis and treatment.

Motivational Interviewing means a directive client-centered counseling approach that elicits behavior change by helping clients to explore and resolve ambivalence.

Participant means employees, dependents and retirees of the Employer who receive their health benefits under the Plan.

Patient-Centered Primary Care Home (PCPCH) means a health care team or clinic, as defined in ORS 414.655, which meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.

Pay for Performance means a program through which the TPA rewards Network Providers for meeting or exceeding targeted performance on specific quality measures.

Plan means the set of benefits offered by the Employer through the TPA through an agreement.

Population-based Contract: means a payment arrangement where the TPA contracts with a provider who agrees to accept responsibility for a set of health services for a group of patients in exchange for a set amount of money. If the provider effectively manages cost and performs well on quality of care targets, then the provider may keep a portion (or all) of the savings generated, but if the provider does not perform well then it may be held responsible for some (or all) of the additional costs incurred.

Primary Care Provider (PCP) means a clinician, including a physician, nurse practitioner or physician assistant, who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority.

Prior Authorization means the pre-review of a service for medical necessity to determine whether it is reimbursable under the Plan.

Provider means primary care and specialty physicians, hospitals, outpatient and ancillary facilities participating in the TPA's network for the purposes of this Plan.

Team-based care means the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by each patient – to accomplish shared goals within and across settings to achieve coordinated high-quality care.

Telemedicine means the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology.

Third Party Administrator (TPA) means the entity responsible for providing Plan administration services on behalf of an Employer and contracting with a provider organization(s) representing a defined network for purposes of providing benefits to Participants.

Value-based Network Design means the explicit use of employee health care plan benefits to create consumer incentives for the use of high performance providers who adhere to Evidence-based treatment guidelines.

Value-based Plan Design means the explicit use of plan incentives to encourage enrollee adoption of one or more of the following, including but not limited to:

- appropriate use of high value services, including certain prescription drugs and preventative services;
- adoption of healthy lifestyles, such as smoking cessation or increased physical activity; and
- use of providers who adhere to evidence-based treatment guidelines.

Model Contract Provisions

I. Contract Purpose

[Employer Name] (Employer)is entering into this Contract with [TPA name] (TPA) for the purpose of purchasing administrative services to support a value-based health insurance product for its employees and dependents that includes the key elements of the Coordinated Care Model (CCM) with a primary objective of improving health care outcomes and quality while reducing costs. Key elements of the CCM include:

- Best practices to manage and coordinate care
- Sharing responsibility and engaging members in better health
- Measuring provider performance
- Paying for outcomes and health
- Providing information to Participants about price and quality
- Financially sustainable rate of health care cost growth (per member)

Employer purchasing strategy is focused on the fundamental belief that collaboration is essential to providing affordable, value-added benefits. Employer seeks to utilize the services of [TPA] to help meet its goal of purchasing care through a healthcare delivery system that is accountable for costs and outcomes.

TPA agrees to partner with Employer in its efforts to achieve better health, better care and lower costs consistent with the principles laid out above.

II. Comprehensive Services

[This section of the Contract will detail the services that the employer wishes to purchase, consistent with the CCM. At a minimum, employers should ensure that the following contract language guides their purchasing activities and contractual arrangements with a TPA. Additional language has been developed (denoted as optional) for some of the areas below that can be adopted by employers wishing to be more transformative in their benefit purchasing and design].

a. **Covered Services**: TPA shall arrange for provision of all of the services required by the Employer under the Contract. At a minimum, services shall meet the Essential Health Benefits requirements of the Affordable Care Act.
    i. The TPA shall implement cost-sharing and benefit design options elected by the Employer that incentivize Participants to access preventive care and evidence-based services and engage in healthy behaviors.

b. **Primary Care Provider (PCP)**:
    i. All Participants shall be required to identify a PCP to provide primary care services.
    ii. TPA shall develop a process through which Participants select a PCP.
        1. The TPA's provider directory shall include all available PCPs within the TPA's network. As detailed in Section III below, the provider directory shall include information to assist a Participant in selecting the most appropriate PCP for his or her needs.
        2. The TPA shall provide the Participant with information on how to select a PCP upon enrollment, including but not limited to:
            a. How long a Participant has to select a PCP
            b. How the Participant selects the PCP
            c. How a PCP will be assigned to plan participants who do not select a PCP.
            d. Whether and how often a Participant shall have the option to select a different PCP.
        3. The TPA shall require PCPs to reach out to plan participants who have selected or been assigned to them specifically to establish a relationship with each attributed Participant if the clinician has never treated the Participant. The requirement shall describe how the PCP is expected to reach out to patients and the timeframe for doing so.

c. **Care Management Services**: TPA shall provide Care Management for patients at high-risk of future intensive service use.
    i. TPA shall identify Participants for care management based on:
        1. Presence of one or more poorly controlled chronic conditions, including:
            a. Asthma
            b. Diabetes
            c. Coronary Disease
            d. Chronic Obstructive Pulmonary Disease
            e. Heart Failure
            f. Depression
            g. Chronic Pain
            h. Substance Use
        2. Complex hospital course, length of stay, or unplanned hospital admissions;
        3. Review and identification of high cost cases;

4. High volume emergency department utilization (six visits in three months); and/or
5. Referral from providers, family members or the Participant.

ii. TPA shall work with identified Participants to actively engage them in care management services focused on improving or stabilizing the Participant's health and securing appropriate and cost-effective services, supplies and treatment.
    1. TPA shall make at least three attempts, at different times of the day, using different methods to engage Participants in care management.

iii. For Participants identified for and engaged in care management services the TPA shall assess Participant's health status, develop a plan of care, provide specific interventions as appropriate based on an individual's particular care needs, and provide education and self-management skills, coordination, facilitation and ongoing supports to the Participant.
    1. *TPA's care managers shall use evidence-based practices, such as motivational interviewing, to enhance their ability to engage Participants in self-care* (Optional).

iv. TPA may provide care management itself, or in combination with a coordinated provider entity. In providing care management, TPA shall work closely with providers to avoid duplication of services.
    1. TPA shall develop and share protocols for coordinating care management services with its Provider Network, including Primary Care Providers. Such protocols should provide flexibility on a case-by-case basis as needed to best serve the Participant.

d. **Case Management Services**: TPA shall provide Case Management for patients who do not meet requirement for care management services, but who would benefit from care coordination and navigation services.

i. TPA shall identify individuals that do not meet the requirements of Care Management Services but may benefit from Case Management.
    1. Individuals may be identified based on claims history, including lack of claims for certain services (such as PCP visits, appropriate screenings) or high use of the emergency department.
    2. Individuals may also be referred to Case Management through referrals from TPA customer service, providers, family members or self-referrals from Participants.

ii. TPA shall assign a case manager to work with identified Participants to actively engage them in Case Management services focused on assisting Participants with accessing care and making linkages with appropriate community-based services.

e. **Integration of Physical and Behavioral Health Care:** TPA shall ensure that an increasing percentage of Primary Care Providers in the provider network offer behavioral health and primary care services that are integrated through the application of evidence-based best practice strategies.
    i. TPA shall encourage co-location of physical and behavioral health care professionals, integrated medical records, use of a shared treatment plan, and integrated payment models.
        1. *TPA shall also encourage reverse co-location (that is primary care providers within a behavioral health site). (Optional)*
        2. *To encourage integration, TPA shall implement an enhanced fee and/or technical support, funded by Employer, to Network Providers that participate in alternative payment models that integrate physical and behavioral health care. (Optional)*

f. **Formulary Development:** TPA shall cover prescription drugs included in a drug formulary or preferred drug list developed for Employer, with covered prescription drugs and cost-sharing amounts that supports a value-and evidence-based purchasing strategy.
    i. The TPA shall allow access to prescription drugs outside of the formulary for special circumstances.
    ii. The TPA shall review the formulary at least annually.

g. **Use of Telemedicine:** Where appropriate, TPA shall authorize health care services to be provided through telemedicine to increase access and treatment and reduce barriers to treatment, including access issues caused by wait times and travel times to the nearest provider.

III. Network Design and Management

This section of the Contract will detail the required network and how the Plan should manage its provider network. The TPA shall provide Employer with the opportunity to review and approve the methods it will use to meet and monitor these requirements over the course of the Contract.

a. **Provider Network.** The TPA shall make available to Participants a Network of Providers sufficient to deliver timely access to the health services covered by the Plan and detailed in Appendix A. The TPA shall provide sufficient access for routine, urgent and emergent care within a reasonable geographic coverage area.
    i. At a minimum, the Provider Network shall include:
        1. Primary care;
        2. Specialty care;
        3. Ancillary services, including community and home-based services;
        4. Inpatient and outpatient facility care;

5. Skilled nursing and rehabilitative care;
6. Pharmacies; and,
7. Behavioral health care (including mental health and substance use services).

ii. The Provider Network shall include sufficient capacity so that Participants may access services within a 30- minute travel time for primary care and acute care services, and within an hour for specialty care.

iii. The TPA will ensure sufficient access by:
1. Requiring providers to deliver emergent care;
2. Requiring providers to offer same-day appointments for routine and urgent services for both medical and behavioral health care;
3. Requiring providers to offer appointments outside of regular business hours;
4. Providing access to services through telemedicine, where appropriate; and,
5. Identifying and acting on opportunities to improve access.

iv. The TPA will monitor the adequacy of its Network on an ongoing basis to ensure appropriate capacity to serve Participants in a timely manner and report to Employer at least annually on Network capacity. .

v. The TPA shall provide Employer with notice of material changes to the Network in advance, or as soon as reasonably possible.
1. Such notice shall include an analysis of the remaining Network's capacity to serve Participants.
2. Such notice shall include a plan to ensure appropriate transfer of a Participant's care in a way that is timely and burden-free for the Participant.

b. **Patient Centered Primary Care Homes**. TPA shall encourage its PCPs within its Network to operate as Patient Centered Primary Care Homes (PCPCH).

i. At a minimum, 65% of the Employer's group shall receive primary care services through PCPCHs by Year 2.
1. *Alternative: The number of Participants receiving care through a PCPCH could be modified:*
a. *85% (very aggressive)*
b. *75% (moderately aggressive)*

ii. The TPA shall support PCPCHs with information, including but not limited to high-risk patient lists, comparative costs of referral providers, and utilization, quality and cost measures for attributed Participants.

iii. The TPA shall measure the PCPCHs performance using appropriate measures.

1. The TPA is encouraged to use performance measures that align with those being used to measure PCPCHs by the CCOs, accessible beginning on page 106 of the PCPCH Technical Assistance Guide, available at http://www.oregon.gov/oha/pcpch/Documents/TA-Guide.pdf.

iv. The TPA shall hold PCPCHs accountable for performance.

1. TPA shall produce regular PCPCH provider performance reports and share the results of those reports with the PCPCH.
2. *TPA shall provide PCPCHs with opportunity to earn incentive payments determined by performance on identified quality measures. (optional)*

v. The TPA shall support an increasing number of PCPCHs in its Network over the term of the Contract and shall support PCPCHs in achieving the highest level of medical home certification as defined by OHA or other commonly used guidelines, through use of enhanced fees, supplemental payments and/or technical assistance support. (Optional)

1. *Alternative Language: The TPA shall support an increasing number of PCPCHs in its Network over the term of the Contract and shall support PCPCHs in achieving the highest level of medical home certification as defined by OHA or other commonly used guidelines, by providing financial support (differentially based on the tier level achieved) to PCPCHs for meeting the PCPCH standards.(Optional)*

c. **Team-based Care**: TPA shall encourage its Network Providers, beyond PCPCHs, to provide coordinated, team-based care across appropriate disciplines through the application of a common, shared care plan and clinical information exchange.

i. TPA shall provide trainings for Network Providers related to the clinical evidence supporting coordinated team-based care and how to transform their practices to meet such requirements (Optional)

ii. TPA shall require an increasing number of its Network Providers to practice coordinated team-based care over the life of the Contract (Optional). Stronger alternatives to this language:

1. *TPA shall require all Network Providers to provide coordinated, team-based care (Extremely Aggressive)*
2. *TPA shall require its Network Providers to provide coordinated, team-based care by Year 3 of the Contract (Very Aggressive)*
3. *TPA shall have 75% of its Provider Network providing coordinated, team-based care by Year 3 of the Contract (Aggressive)*

4. *TPA shall have 50% of its Provider Network providing coordinated, team-based care by Year 3 of the Contract (Moderate)*
5. *TPA shall have 25% of its Provider Network providing coordinated, team-based care by Year 3 of the Contract (Easiest).*

iii. TPA shall develop and implement a monitoring plan to assess its Provider Network's progress in implementing team=based care.

d. **Value-Based Network Design***: The TPA shall have the capacity to implement varied cost-sharing for Network Providers by provider performance. (Optional)*

i. The TPA shall review provider quality performance and tier providers into three levels based on performance using a methodology approved by the Employer.

ii. Providers at the highest quality tier based on performance shall have the lowest cost sharing; providers with the lowest performances shall have the highest cost sharing.

iii. At Employer request, the TPA shall develop a high-performing network limited to providers who distinguish themselves as high quality providers based on evidenced-based, statistically meaningful and risk-adjusted measures of quality, cost and efficiency.

e. **Provider Directory:** The TPA shall provide a web-based directory of Network Providers available under the Plan, and will make regular updates to the directory. At a minimum, the provider directory shall include the following information:

i. Provider name and location

ii. Provider type, specialty area and certifications, if any

iii. Languages spoken

iv. Provider tier (optional)

IV. Evidence-based Care

This section of the Contract will detail requirements for implementation of best practices and how the performance of those activities by Network Providers will be monitored.

a. **Health Risk Assessment (HRA)**: TPA shall offer a self-reported HRA to each Participant.

i. The TPA shall identify an HRA that collects sufficient information regarding a Participant's demographics, chronic diseases, injury risks, modifiable risk factors and urgent health needs to identify potential need for complex care management or other services, and to develop a personalized prevention plan for Participants.

ii. The HRA must be written at a 6th grade level and all questions in the HRA must be actionable, i.e., have a corresponding evidence-based strategy.

iii. The HRA should be available through a web-based system, at a minimum, and take no more than 20 minutes to complete.

b. **Patient Activation and Shared Decision Making:** The TPA shall implement and shall require its Network Providers to use strategies that activate and engage Participants in their health, including through health behaviors that modify risk factors and self-management of any chronic conditions.
    i. The TPA shall provide and require its Network Providers to offer services in a culturally competent manner that meaningfully and actively engages Participants.
    ii. The TPA shall support Network Providers in patient activation through a combination of training and standardized tools, including tools that support shared-decision making.
        1. The TPA and its Network Providers shall solicit Participant preferences with respect to functional outcomes, recovery or rehabilitation expectations, and risk tolerance;
        2. The TPA and its Network Providers shall explain treatment options as may be clinically recommended based on Participant risk profile and/or disease state progression; and,
        3. The TPA shall monitor claims and referral patterns to identify opportunities to support decision making around treatment options.
    iii. The TPA shall monitor Network Providers efforts to implement patient activation by monitoring participation in training activities and use of standardized tools.

c. **Medical Management**: The TPA shall provide the following basic medical management services, except in those instances in which the TPA has delegated one or more of the following responsibilities to a qualified provider entity that has contracted using an alternative payment model:
    i. Clinical Protocols: TPA shall identify and implement clinical protocols with its provider network that are evidence-based, designed to maximize patient health status, clinical outcomes and efficiency, and reduce overuse of services. Such protocols shall be in addition to practice guidelines used for prior authorization and concurrent review processes.
    ii. Prior authorization: TPA shall develop policies and procedures related to prior authorization, including when and how prior authorization shall be required.
        1. *The TPA shall consider the coverage guidelines established by the Health Evidence Review Commission (HERC) in developing its prior authorization process (Optional: stronger language may say "require" instead of consider)*

2. *TPA may exempt certain providers from obtaining prior authorization based on the historical appropriateness of requests, its overall quality scores and use of alternative payment methodologies. (Optional)*

iii. Concurrent review: TPA shall conduct initial and current reviews of medical and surgical inpatient hospital and skilled nursing facility stays to determine the appropriateness of the setting, level of care and length of stay.

1. *TPA may exempt certain providers from concurrent review based on historical appropriateness of admissions, its overall quality scores and use of alternative payment methodologies. (Optional)*

iv. Discharge Planning and Transition Management: TPA shall ensure that there is appropriate discharge planning and coordination between the TPA, the facility, community-based providers and care managers, where appropriate, to assure safe transitions and decrease the risk of avoidable re-admission.

V. Quality and Performance Measurement

[This section of the Contract will detail the requirements for monitoring the quality of care provided to Participants and efforts to improve that quality.]

a. **Quality Oversight**: The TPA shall have a strategy for quality oversight of the care being provided to Participants by Network Providers.

i. The TPA shall develop an annual quality strategy and maintain quality staff to implement that strategy.

1. The quality strategy should include details on how the TPA shall monitor quality and describe the TPA's Quality Improvement Program (QIP).
2. On an annual basis the TPA shall report to Employer the quality improvement projects it has undertaken during the year and its progress on those activities.

ii. Quality Improvement Program: On an annual basis the TPA shall identify 4 QIPs focused on improving Participants' health outcomes.

1. *At least one QIP shall focus on improving health outcomes for Participants with more than one chronic condition. (Optional)*
2. *At least one QIP shall focus on reducing preventable hospital admissions and readmissions. (Optional)*

b. **Performance Measurement**. Comprehensive performance measurement, aligned across payers, supports identification of performance improvement

opportunities and provider performance accountability purchasers while easing the burden of reporting for providers.

i. The TPA shall utilize performance measures to monitor Network provider quality performance. Measures shall be endorsed by the National Quality Forum or another national body. Measures shall address the following domains of performance: preventive care, chronic illness care, mental health and substance use treatment, efficiency, overuse, patient experience, medication management, access, utilization and coordination of care.

ii. The TPA shall report the following cost measures: total charges, total payments, payments per Participant, and payments by place of service, type of provider, diagnostic category, and high volume provider.

   1. *Alternative: The TPA shall adopt and utilize the set of standardized provider performance measures that are aligned with measures developed as part of a consensus process which aligns measures across major public and private payers, including commonly defined measures in each of the following domains and stratified by major subpopulations: a) access, b) quality, c) patient experience, d) patient activation, e) service utilization, and f) cost. These performance measures shall be reported to the appropriate state agency or entity, including where applicable to the All Payer All Claims (APAC) Reporting Program.*

iii. TPA health informatics. The TPA shall perform analysis of claims and clinical data to identify a) population characteristics, b) variations in care delivery, costs and avoidable complications, c) provider deviation from practice guidelines and/or clinical pathways, d) patients at risk for future high-intensity service use. The TPA shall:

   1. measure performance across all provider types and providers with meaningful volume for the TPA's book of business.

   2. apply clinical risk adjustment techniques when measuring provider performance and utilize socio-economic risk-adjustment techniques to the extent available.
   3. at request of Employer, provide monthly data files for analysis by Employer

iv. Network Provider informatics. The TPA shall require contracted providers operating under population-based contracts to:

   1. perform analysis of integrated claim and clinical data to identify a) population characteristics, b) variation in care delivery, costs and avoidable complications, c) provider deviation from practice

guidelines and/or clinical pathways, d) patients in need of evidence-based services, e) patients at high risk of future high-intensity service use.

2. measure performance at the clinician, practice team and/or practice site, and organizational levels.

VI. Payment Strategies

The TPA shall develop payment strategies and implement payment models that reward quality and efficiency rather than volume of services provided. The TPA shall consider implementing alternative payment methodologies such as population-based payment, episode-based payment, and payment incentives for high quality and/or improved quality and lowered cost growth. The TPA shall increase the use of systems of alternative payment models over the course of the Contract and shall report to Employer on its progress on an annual basis. By the end of Contract Year 3, 50% of TPA's payments shall be made through alternative payment methodologies. Savings distributions to contracted providers shall be contingent on quality performance. The TPA may include, but is not limited to, the following payment strategies:

a. **Population-based Contracts**. The TPA shall take such actions as are necessary to annually increase the proportion of providers agreeing to participate in population-based contracts.
    i. Any Population-based Contracts shall be risk adjusted, and shall not place participating providers at undo risk which may threaten solvency
    ii. Prior to entering into a Population-based Contract, the TPA shall conduct a readiness assessment to confirm that participating providers have necessary infrastructure to administer Population-based Contracts, including:
        1. a contracted network of providers
        2. an appropriate governance structure
        3. clinical leadership
        4. care management capacity
        5. health information analysis and reporting capacity
    iii. In order to share in any savings, Network Providers must meet quality benchmarks.
    iv. Additional optional measures for inclusion:

        1. By the end of Contract Year 3, claims for at least 60 percent of Participant lives shall be covered under a population-based contract with shared savings, and claims for at least 20 percent of

insured covered lives shall be paid under a population-based contract with risk sharing. (Aggressive)

2. *By the end of Contract Year 3, claims for at least 45 percent of Participant lives shall be covered under a population-based contract with shared savings, and claims for at least 10 percent of insured covered lives shall be paid under a population-based contract with risk sharing. (Moderate)*

3. *By the end of Contract Year 3, claims for at least 30 percent of Participant lives shall be covered under a population-based contract with shared savings or with risk sharing. (Easiest)*

b. **Episode-based Payments**. The TPA shall evaluate and consider whether to implement episode-based payment strategies designed to bundle a set of services together that are related to a defined condition or treatment. *Optional language to expand the focus on episode-based payments include:*

i. The TPA shall design and implement an episode-based payment strategy designed which bundles all services related to knee replacement surgery.

ii. The TPA shall design and implement an episode-based payment strategy designed which bundles all services related to maternity care, including pre-natal care, birth and post-natal care for 6 weeks following the birth.

c. **Pay for Performance**. The TPA shall design and implement a Pay for Performance strategy for providers that are not able or ready to participate in other alternative payment methodologies.

i. The TPA shall select certain measures as described in Section V above.

ii. The TPA shall determine baseline measurement, appropriate benchmark and improvement targets, and incentive payments linked to each measure.

iii. The TPA may withhold a portion of a provider's fee-for-service payment over the course of the year to fund the Pay for Performance program. (Optional)

d. **Strategies designed to reduce waste.** The TPA shall design and implement payment and coverage approaches that cut waste while not diminishing quality, including reducing unwarranted payment variation. In evaluating strategies to reduce waste, the TPA should consider the following strategies at a minimum:

i. reference pricing,

ii. non-payment for avoidable complications and hospital-acquired infections,

iii. lower payment for non-indicated services and

iv. warranties on discharges for patients who undergo procedures.

e. **Strategies designed to support primary care.** The TPA shall support PCPCH transformation and operation, ensuring that the level and method of compensation support an effective primary care infrastructure, through the use of enhanced fee schedules, supplemental payments and/or primary care capitation.

VII. Information Technology (IT)

a. **Use of electronic health records (EHRs)**.The TPA shall work with its provider network to increase the adoption and meaningful use of certified EHRs.[3]
   i. The TPA shall require physicians across care settings to adopt and meaningfully use certified EHRs.
      1. Such providers shall further be required to implement processes to ensure data completeness and accuracy.
   ii. The TPA shall require all contracted providers, in addition to physicians, to adopt and meaningfully use certified EHRs. (Optional – Very Aggressive)
   iii. The TPA shall provide Participants secure electronic access to clinical health records, through a patient portal or other vehicle.
      1. Such access can be provided through the TPA or the Participant's provider.
      2. Participants shall have the capacity to share information electronically with their providers.

b. **Electronic Health Information Exchange (HIE)**. The TPA shall encourage physicians and hospitals within its provider network to exchange real-time electronic clinical information exchange across all care settings to facilitate care coordination among treating care providers, including those across organizational and technological boundaries. *Alternative language for more aggressive implementation follows.*
   i. The TPA shall require contracted physicians and hospitals to use real-time electronic clinical information exchange across care settings to facilitate care coordination among treating care providers, including those across organizational and technological boundaries. (Aggressive)
   ii. The TPA shall require all contracted providers to use real-time electronic clinical information exchange across care settings to facilitate care coordination among treating care providers, including those across organizational and technological boundaries.. (Very Aggressive)

[3] See http://oncchpl.force.com/ehrcert

VIII. Transparency

The TPA shall make accurate and understandable data on cost and quality readily available to Employer, Network Providers and Participants.

a. **Full disclosure of provider quality performance to allow comparison.** The TPA shall develop and implement a strategy to report the comparative performance of Network Providers.
    i. The TPA shall use the measurement set described in Section V.
    ii. The TPA shall compare providers to state, regional and/or national benchmarks
        1. Reported differences should be statistically significant
        2. Measures for providers with insufficient denominators should not be reported.
    iii. The TPA shall make its findings easily accessible and meaningful to Participants.
        1. Information shared shall reflect a diverse array of provider clinical attributes and activities, including but not limited to:
            a. Provider background
            b. Quality performance
            c. Patient experience
            d. Volume
        2. Information shall be explained in clear terms at a 6th grade-reading level.

b. **Full disclosure of price per provider per services to allow comparison.** The TPA shall make specific provider price information transparent to the Employer and Participants.
    i. Price transparency shall cover services representing at least 80% of the TPA's medical spend in all markets.
    ii. Disclosed information shall be based on the contracted price of specific procedures and services.
    iii. Price shall be provided in a manner that provides Participants with detailed information to understand the total price of the service, including Participant cost-sharing.

IX. Contractor Performance

This section of the Contract details the Employer's financial performance expectations of the TPA under the Contract.

a. **Overall sustainable rate of growth.** The TPA shall work to aggressively bend the health care cost curve, while ensuring Participants receive high quality care.
    i. The TPA shall limit annual rate of growth in its Network Provider contracts to the Consumer Price Index (CPI).
    ii. Within population-based contracts with Network Providers, the TPA shall include a provision that the risk-adjusted annual increase in the total cost of care for services reimbursed under the Contract shall be CPI plus 1%.

b. **Reporting Requirements.** The TPA shall provide regular reports to Employer to allow for assessment and monitoring of TPA performance to Contract requirements. Specifically, TPA shall provide Employer with reports on an agreed upon schedule using a reporting template and content approved by Employer on, at a minimum, the following areas of TPA performance:
    i. Quality measurements, as described in Section V above
    ii. Network Performance, including:
        1. Provider capacity and timely access to care
        2. Increase in PCPCHs within network
        3. Status of alternative payment model contracting across Network
    iii. Cost Performance relative to sustainable rate of growth
    iv. Service Utilization
    v. Summary of Participant HRA results
    vi. Annual analysis of opportunities and recommendations for improved quality and cost

c. **Performance guarantees.** The TPA shall meet the performance and reporting requirements within this Contract.
    i. Failure to meet these requirements shall result in a corrective action plan and potential reduction or forfeiture of the portion of the TPA's administrative fee. .
        1. The TPA shall also be at risk for not meeting basic administrative tasks, including but not limited to paying claims accurately and in a timely manner.
        2. The total amount at risk shall be equal to 5% of total health care payment made through the Contract.
    ii. TPA shall be eligible for a performance bonus for improved quality and reduced costs. The maximum performance bonus shall be equal to the 5% of the total health care payment made through the Contract.
        1. Bonuses shall only be paid if the TPA's cost and quality performance comes in below (better than) the targeted amount.

Oregon Health Authority

PATIENT-CENTERED PRIMARY CARE HOMES

BETTER HEALTH, BETTER CARE AND LOWER COSTS

January 2016

Patient-Centered Primary Care Homes: Good Return on Investment for Employers

As the largest purchasers of health care in America, employers are paying a high price for care of variable quality. To check soaring costs, some employers are implementing payment models that reward high value.

There is emerging evidence that patient-centered medical home programs (both nationally and in Oregon) are yielding a good return on investment for employers.[1,2] This brief provides more information about the Patient-Centered Primary Care Home and highlights some of the early success of the medical home model in Oregon and in other national organizations.

Benefits of a PCPCH

- Coordinated care to help employees get the services they need, when and where they need them
- Helps employees play an active part in their health
- Offer employees after-hours help and alternatives to the emergency room
- Drive down costs for employers by focusing on preventive care, wellness, and managing chronic conditions

The Oregon Way: Patient-Centered Primary Care Homes (PCPCH)

A PCPCH is Oregon Health Authority's version of a "medical home," which is a primary care practice that gives patients the individualized care and support they need to stay healthy. In a medical home, the patient, the primary care physician, and a medical team work together to develop and implement a holistic plan of care for the patient. Primary care homes reduce costs and improve care by catching problems early, focusing on prevention, wellness and management of chronic conditions. PCPCHs receive supplemental monthly payments on top of their traditional fee-for-service payment to provide this enhanced patient support.

Learn more about the PCPCH program at www.primarycarehome.oregon.gov

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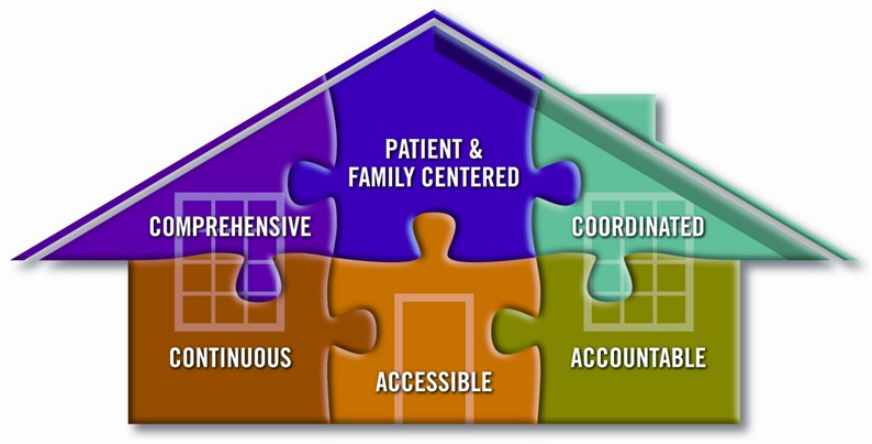

Core Attributes of a Patient-Centered Primary Care Home (PCPCH)

PCPCH Core Attributes

Accessible: Care is available when patients need it.

Accountable: Practices take responsibility for the population and community they serve and provide quality evidence-based care.

Comprehensive: Patients get the care, information and services they need to stay healthy.

Continuous: Providers know their patients and work with them to improve their health over time.

Coordinated: Care is integrated and the clinic helps patients navigate the health care system to get the care they need in a safe and timely way.

Patient and Family Centered: Individuals and families are the most important part of their health. Care draws on a patient's strength to set goals and communication is culturally competent and understandable for all.

Across the nation there is emerging evidence that patient-centered medical home programs are yielding a good return on investment in terms of employer costs and patient outcomes. If you are interested in learning about national case studies of employers please see http://www.bailit-health.com/articles/022613_bhp_paymentbrief_pcmh.pdf.

Case Study #1: Metropolitan Pediatrics

Metropolitan Pediatrics has four locations in the Portland Metropolitan area and first became recognized as a medical home by the PCPCH Program in 2011. In 2015, all four practice locations achieved the new PCPCH 3 STAR criteria for the most advanced medical homes. By investing in robust population health management tools, Metropolitan Pediatrics gained a better understanding of their patients' needs. For example, they found that asthma was the most common chronic condition, and then implemented the latest evidence-based asthma care guidelines. They added RN complex care management and an immunization improvement program. Through these efforts, they achieved a 28% decrease in ED costs, lower inpatient and admission rates for their asthma patients, and immunization rates 22% higher than the rest of Oregon.

Metropolitan Pediatrics continues to expand their medical home model through integrated behavioral health clinicians, dieticians, a new and better connected electronic health records system, annual patient surveys, the creation of parent advisory committees for community outreach and enhanced access to after-hours care. They have fully adopted a team-based approach to caring for children and families, and continuously push themselves to provide the best possible care. In 2016 they will lead advancement of Pediatric services in a new direction with the implementation of Adverse Childhood Experiences (ACES) Resiliency training to focus on appropriate care and support of childhood adverse events.

Case Study #2: Winding Waters Clinic in Enterprise, Oregon

Winding Waters began their transformation in 2009 when they became part of the Safety Net Medical Home Initiative - a national Patient-Centered Medical Home demonstration to help 65 primary care safety net sites become high-performing medical homes -- improving quality, efficiency and the patient experience. Their first steps towards transformation included increasing access through open access scheduling, expanded hours, and implementation of a team-based model of care.

As a result of these early transformation efforts, wait times for follow-up appointments dropped from twelve days in 2009 to same day access in 2015, wait times for refill requests dropped from 5 business days in 2009 to 2 hours in 2015, and average scheduling wait time for physicals dropped from 36 days in 2009 to 3 business days in 2015. Additional data collected from 2008 to present show a clear reduction in hospital visits (for Winding Waters patients) and emergency room visits (for all of Wallowa County). Specific to hospital visits, there has been an average of 7.25% reduction per year over a six-year period (32.5% total reduction in utilization since 2008). For ER visits, there has been an average of 6.4% reduction per year over a six-year period (28.7% total reduction since 2008). (Continued on next page).

How You Can Get Started

1. Speak with your plan administrator about his or her experience with such programs. Most health insurers are now piloting or operating medical home programs.
2. If you have a large concentration of employees in one or more geographies, approach the largest medical group and/or health system that serves your population and ask about their experience with medical homes or PCPCHs, and their willingness to apply their program or develop a new one to serve your employees.
3. Participate in regional pilot(s)
4. Use a payment methodology that enhances payment to primary care practices
5. Educate employees and dependents about the benefits of affiliating with and using a primary care provider
6. Consider benefit modifications that provide incentives for use of a medical home

Case Study #2: Winding Waters Clinic in Enterprise, Oregon (cont.)

These outcomes were achieved through use of an expanded team approach including care coordination, co-located and integrated behavioral health providers, and trained community health workers.

Winding Waters became a Tier 3 recognized Patient Centered Primary Care Home in 2012, and then became the first 3 STAR Patient Centered Primary Care Home in Oregon in June 2015. Winding Waters was awarded Federally Qualified Health Center status in August 2015 further ensuring sustainable service to the Wallowa County community.

Case Study #3: Michigan Demonstration Project to Improve Patient Care

Through the Centers for Medicare and Medicaid Services, Michigan is one of eight states testing a patient-centered medical home across various payers, including employers and insurers. Under Nearly 1.8 million Michigan residents participate in this demonstration and receive coordinated, patient-centered care from physicians and health teams.

Primary care practices report improvements in the biggest health care challenges — obesity, diabetes, and hypertension. Adult patients in PCMH-designated practices had a 26% lower rate of hospital admissions for common conditions that could be addressed in a primary care setting.

Blue Cross-designated PCMH practices also had a 10.9% percent lower rate of adult emergency room visits and a 22.4% lower rate of pediatric emergency room visits for common chronic and acute conditions, such as asthma. Blue Cross estimates that it has saved $512 million through disease prevention, reduced hospitalizations, and emergency room visits, and management of acute and chronic medical conditions.

Improvements Resulting from the PCPCH Program

Almost 600 primary care homes are recognized statewide, representing over 50% of all eligible clinics in Oregon and serving over 2 million Oregonians, over half the state's population.

1. A 2013 survey of PCPCH recognized clinics found that 85% of practices feel that PCPCH model implementation is helping them improve the individual experience of care and 82% report the model is helping them improve population health management
2. Over time clinics recognized as PCPCHs showed a significant increase in preventive procedures and a significant reduction in specialty office visit use as compared to non-PCPCH clinics.
3. In a recent report from the Oregon Health Care Quality Corporation that compared PCPCH recognized vs non-recognized clinics there were significant measure performance improvements in diabetes HbA1C and LDL-C; diabetes kidney tests; diabetes eye exam; adolescent well care visits; and Chlamydia screening. The report is available at: http://qcorp.org/sites/qcorp/files/qCorp-statewide-report-2015-postpress-corrected-singlepages_WEB-FINAL%20BBF%202.pdf.

Citations:

1. M. Nielsen, A. Gibson, L. Buelt, P. Grundy, K. Grumbach. The Patient-Centered Medical Home's Impact on Cost and Quality.
2. Oregon Health Authority. Patient-Centered Primary Care Home Program 2014-2015 Annual Report.

Oregon Health Authority

PAYMENT REFORM MATTERS

BETTER HEALTH, BETTER CARE AND LOWER COSTS

December 2015

Why is Payment Reform an Important Piece of the Puzzle

Employers are the largest purchasers of health care in Oregon. Health care is expensive and it is of variable quality. Both nationally and in Oregon, there is a concerted focus on improving health care quality and outcomes while reducing cost growth. Payment reform is an important piece of the puzzle. Increasingly, in Oregon and elsewhere, Medicaid, Medicare and the commercial market are changing the way health care is paid for and moving towards alternative payment models that reward high value.

As self-insured employers look to rein in their health care costs, they too should look to implementing alternative payment models that move payment away from fee-for-service and towards models that create financial incentives for high quality, efficient care. There is no one size fits all approach to implementing alternative payment models. They may be implemented across an entire population, or can be focused on specific portions of the population. An employer can implement a number of alternative payment models within its population.

Payment Reform ROI: CALPERS

CALPERS saved over $30 million in costs when it implemented a population-based payment model. These savings were due in part to large reductions (15%) in inpatient readmissions and inpatient days, as well as reduction in surgeries.

Walmart participates in payment reform activities in Arkansas, including episode-based payments and PCMHs

IBM participates in Vermont's PCMH program

Paying for Outcomes and Health

Payment for care should be based on quality and health outcomes rather than on volume of services provided. The alternative payment methodologies described below represent a continuum of payment options that increasingly hold providers accountable for health outcomes — offering incentives for performance and quality outcomes, episode-based payment, and population-based contracting — and support better care and lowered costs. The intent is to increase the use of payment models that improve health outcomes.

See Page 2 for details on these payment models.

Pay for Performance (P4P):
Through P4P arrangements, providers are eligible to receive bonus payments based on meeting or exceeding performance targets on an agreed upon set of performance measures. P4P continues fee-for-service payments, but gives providers some incentive to focus on quality outcomes and not just volume.

Patient Centered Medical Home Payments:
As described in [companion document], a patient centered medical home (PCMH) is a primary care practice that gives patients individualized care and support through a multi-disciplinary care team to help them stay healthy. In Oregon, PCMHs are referred to as Patient-Centered Primary Care Homes (PCPCH). Typically, providers receive a per member per month (PMPM) payment on top of their existing fee-for-service payment to provide enhanced outreach, communication and coordination.

Through advanced practice models, providers develop patient-centered, multi-disciplinary team-based care for patients with multiple chronic conditions. PMPM payments for these types of practices are often significantly higher than for regular PCMHs. PCMHs are foundational elements to more advanced population-based contracting models.

Episode Based Payments (also known as bundled payments):
Under this arrangement, a provider entity agrees to accept responsibility for the health of a patient relative to a particular condition or treatment in exchange for a set dollar amount that is expected to cover the total cost of all condition specific services needed by a patient. .

Population Based Contracting:
Under this arrangement, a provider entity agrees to accept responsibility for the health of a group of patients in exchange for a set dollar amount that is expected to cover the Total Cost of Care. If the provider is able to effectively manage costs and perform well on quality of care targets, then the provider keeps a portion of the savings generated. However, if the provider is not successful and delivers inefficient, high-cost care, then the provider may be responsible for the additional costs incurred over the expected total cost of care. The purpose of population-based contracting is to align the financial interests of providers with the interests of the patients, allowing for innovative approaches to patient-centered care, so that everyone wins if the patients are healthy and costs are contained.

An employer can implement population-based contracting by requiring its Third Party Administrator (TPA) to enter into such contracts with providers in an effort to increase the number of insured lives covered by this type of contract.

Oregon Health Authority

MULTI-STATE EMPLOYERS SHOULD PARTICIPATE IN PAYMENT REFORM

BETTER HEALTH, BETTER CARE AND LOWER COSTS

December 2015

Payment Reform Works for Multi-State Employers

As the largest purchasers of health care in America, employers are paying a high price for care of variable quality. To control soaring costs, some employers — including those with employees in multiple states — are switching from the fee-for-service model to payment models that reward value.

Nationally, there is a movement away from the fee-for-service model, including in Medicare, Medicaid and the commercial market. Examples of payment models that are being implemented nationwide, include pay for performance, payment for patient-centered medical home and care management programs, shared savings, episode-based (bundled) payment models, and population-based payments.

The Coordinated Care Model includes various delivery system reform elements (e.g., patient-centered primary care homes, integration of physical and behavioral health) that can be aligned with payment that supports the particular activity. For example, additional payment could be offered to providers who become a patient-centered primary care home or to those providers reducing specific conditions (e.g., asthma, hospital care) for a specific population.

Examples of Multi-State Employers Participating In Payment Reform

- Walmart participates in payment reform activities in Arkansas, including episode-based payments and PCMHs
- IBM participates in Vermont's PCMH program

Benefits of Alternative Payment Models

- Moves accountability for health outcomes and reduced costs to the providers.
- Increases focus on quality outcomes.
- Reduces incentives to over-utilize unnecessary services.
- Increases incentives to focus on employee engagement and coordinated care. Employees get the services they need, when they need them resulting in improved health outcomes and patient satisfaction.

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Proposed Approach to Return on Investment (ROI) Calculation

Coordinated Care Model

DRAFT - FOR DISCUSSION ONLY

January 20, 2016

Key Assumption:

- ROI will focus both on cost savings and quality improvement from model

Cost ROI

What aspects of the CCM should/can be included?

- Implementation of:
  - PCPCH
  - P4P
  - Electronic Health Records
  - Shared savings
  - Shared risk
- Utilization
  - Reduce ED
  - Reduced hospital admissions
  - Reduced readmissions
  - Total Cost of Care

What literature or other studies should be reviewed for similar analyses?

- Focus on ROI in commercial market
- Also look to results in Medicare and Medicaid
- OR Association of Family Practitioners is putting together an analysis of the cost of implementing a PCMH program (should be finalized by June 2016)

Potential to Get Data from Commercial Insurers

- Moda (both CCO and commercial market)

How would the ROI be calculated?

Broad ROI (TCOC):

- Pre/Post for employer group that has implemented CCM and been with same plan
- Expected spend without CCM compared to actual spend with CCM
- Comparison of non-CCM plan spend to spend of CCM plan

Specific ROI:

- Average costs for utilization (e.g. ED) :
    - expected utilization * expected cost, compared to
    - actual utilization* actual costs
- Note: this calculation won't be able to look at impact on system as whole (e.g., reduced ED cost is not the net savings – and won't know what the costs were in other areas such as urgent care visits, BH services, etc.)

Quality ROI

Look for improved health care outcomes for individuals that obtain coverage through a product with CCM-based initiatives.

- Define OR specific population to measure (CCO, Moda commercial?)
- Look nationally to quality improvement based on CCM-like activities to show potential for improved quality
- Use subset of CCO Quality Measures plus Utilization Measures
    - Should other measures be included?
    - Potential to use targets that are built into the CCO contracts